



Treatment of *Clostridium difficile* in Adults Clinical Pathway

Testing for *Clostridium difficile* is appropriate in patients:

- With unexplained and new-onset ≥ 3 unformed stools in 24 hours
- No administration of recent laxatives or stool softeners
- DO NOT use *C. difficile* PCR for test of cure or on asymptomatic patients

If *C. difficile* infection highly suspected or confirmed:

- Discontinue any unnecessary antibiotics immediately or as soon as possible
- Place patient in Enhanced Contact Precautions (wash hand with soap and water, alcohol based sanitizers alone are not adequate)
- Discontinue any non-required proton pump inhibitor
- Start treatment for *C. difficile* infection (CDI) – see below treatment options
- Consider consultation of ID, GI, and/or General Surgery as appropriate in patients with severe disease (WBC count >15 cells/ μ L, serum creatinine >1.5 mg/dL)

Treatment:

INITIAL EPISODE	
Mild, moderate or severe	Vancomycin 125 mg PO QID for 10 days*
Fulminant episode with hypotension or shock, ileus, megacolon	Vancomycin 500 mg PO QID by mouth or NG tube for 10 days* If ileus, consider adding rectal instillation of vancomycin. Metronidazole IV 500 mg every 8 hours should be administered together with oral or rectal vancomycin, particularly if ileus is present for 10 days*

*All randomized trials have compared 10-day treatment courses, but some patients may have delayed response to treatment and clinicians should consider extending treatment duration to 14 days or longer in those circumstances

RECURRENCE	
First recurrence	Use a prolonged tapered and pulsed vancomycin regimen: 125 mg QID for 10-14 days 125 mg BID for 7 days 125 mg daily for 7 days 125 mg QOD or Q3D for 2-8 week
Second or subsequent	Preferred: Vancomycin in a tapered and pulsed regimen OR Consider FMT (requires GI/ID consult)* Alternate: 1) Vancomycin 125 mg PO QID for 10 days followed by rifaximin 400 mg TID for 20 days OR 2) Fidaxomicin 200 mg PO daily for 10 days**

*Expert opinion states appropriate antibiotic treatment for at least 2 recurrences (i.e., 3 CDI episodes) should be used prior to offering fecal microbiota transplantation

**Maybe preferred in patients at highest risk for recurrence: ulcerative colitis/inflammatory bowel disease, hematopoietic stem cell transplant and end stage renal disease